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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on March 8 through March 12, 2010, in accordance with 42 CFR Chapter IV Part 483, Requirements for Long Term Care Facilities. The census at the time of the survey was 124. The sample size was 24 including 3 closed records. There were 5 unsampled residents. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that my be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	F 000		
F 154 SS=E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that the	F 154		4/12/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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resident or their legal representative were informed of the risks and benefits of treatment, and signed appropriate consents for: psychopharmacological medications for 3 of 24 residents (Residents #7, #8, and #21), general treatment by the facility for 1 of 24 residents (Resident #21), and dialysis for 1 of 24 residents (Resident #18).

Findings include:

Resident #7

Resident #7 was admitted to the facility on 11/12/09, with re-admission on 12/30/09. Diagnoses included protein-calorie malnutrition, cachexia, diabetes, depressive disorder, and abnormal weight loss. Review of the resident's record revealed that there was a new order for the anti-psychotic Abilify 2 milligrams (mg) daily "for mood." The resident had been given this medication since 3/4/10. There was no signed/dated consent for Abilify.

Resident # 8

Resident #8 was admitted to the facility on 12/29/09, with diagnoses including diabetes, hypertension, gastrostomy, chronic obstructive pulmonary disease, gastroesophageal reflux disease, dysphagia, and depressive disorder. Medication orders included the antidepressant Lexapro 5 mg daily, and the hypnotic Restoril 15 mg at bedtime as needed. The consents for these medications had the signatures of two nurses, along with a statement "verbal consent" and the date of 12/31/09. There was no signature from the resident on the consent form. The Director of Nursing (DON) confirmed that the

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consent forms had not been signed by Resident #8. The DON also confirmed there was no facility policy outlining when consents should be signed after a verbal agreement was made.

Resident # 21

Resident #21 was originally admitted to the facility on 10/13/06, with a re-admission date of 10/6/09. Diagnoses included congestive heart failure, gastroesophageal reflux disease, depressive disorder, hypothyroidism, and anxiety state. Medication orders included the antipsychotics Risperdal 1 mg twice a day and Seroquel 50 mg twice a day, with a start date of 2/28/08. The consents for these two medications were unsigned, with the note, "pending public guardian." The facility's consent for treatment form was also unsigned. The DON explained that there was no facility policy outlining who was responsible for signing consents if the resident was cognitively impaired and had no legal guardian.

Resident #18

Resident #18 was admitted to the facility on 1/27/10 with diagnoses including end stage renal disease, diabetes type II, osteomyelitis, status post amputation of the toe, hypertension, generalized pain, congestive heart failure, insomnia and depression. Physician's orders included dialysis treatments three times a week in the facility. The order specified the facility's contractor was to provide the resident's dialysis treatments.

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Review of Resident #18's medical record revealed a general consent for treatment had been obtained from the resident. There was no documentation that the risk and benefits of dialysis had been discussed with the resident or evidence a consent for dialysis treatments was obtained from the resident.

On the morning of 3/11/10, an interview with the Administrator, the Director of Nursing (DON) and facility's contract Dialysis Manager was conducted. The Administrator, DON and Dialysis Manager agreed and confirmed that they had not obtained consents for dialysis treatments for Resident #18 or the other three residents that were receiving dialysis at the facility. The Administrator, DON and Dialysis Manager indicated that they thought the facility's general consent for treatment, which is signed by all residents upon admission, was sufficient.

The facility's general consent, which was undated and titled "Consent For Treatment" consisted of one paragraph which read: "I, the undersigned, hereby consent to and authorize the administration of all treatments/procedures that may be considered and advisable and/or necessary in the judgement of my physician (or physician members of the Medical Staff to whom the resident is referred). Education information shall be shared with the resident and Family." The Consent For Treatment did not outline any risk or benefits.

Review of the facility's dialysis contractor's services and guidelines, which were undated and titled "(Contractor Name) Dialysis Services" and "(Contractor Name) Dialysis Services Guidelines," indicated the following:

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F 154	Continued From page 4 1) Admission Process; Obtain Hemodialysis consent 2) Consent for hemodialysis must be signed before treatment is started The information regarding the requirement for obtaining a consent for dialysis prior to treatment, had been presented by the Dialysis Manager to facility staff in two inservices conducted on 12/15/09 and 2/9/10. Review of the consent form used by the facility's dialysis contractor, which was undated and titled "(Contractor Name) Dialysis Services LLC - Authorization For and Verification of Consent to Acute Renal Services" was concise and comprehensive. The consent form included education on the need for treatment, explained the types of dialysis, the risks and benefits, as well as possible side effects. Serious risks included the possibility of excessive bleeding as a result of clotting problems or external bleeding due to disconnection of the bloodline. Possible reactions and side effects outlined the possibilities of fatal shock or cardiac arrest.	F 154		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		4/12/10

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Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to ensure the confidentiality clinical information by not securing residents' medication information.

Findings include:

During the initial tour of the facility the morning of 3/8/10, it was noted that two medication carts were "parked" in an unoccupied resident room (Room 8). On top of one of the carts were three unit dose cards, which were empty of medication, but did identify the resident by name and the name of the three medications as well as the dosage and frequency of administration.

On 3/9/10 at 8:30 AM, a medication cart was

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F 164	Continued From page 6 located on the D wing, between room 53 and 54. The medication cart was unattended. The medication administration record (MAR) was open to a resident's medication page. This page included diagnoses and medication information. On the top of the medication cart was also a refill label which included a resident's name and drug information. The medication cart was left unattended for approximately 10 minutes until the Licensed Practical Nurse (LPN) returned to the cart. Upon return to the medication cart, the LPN was interviewed at 8:40 AM on 3/9/10 and acknowledged the MAR should have been closed to prevent easy access to resident medical information.	F 164		
F 168 SS=C	483.10(g)(2) RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post Nevada's Bureau of Health Care Quality and Compliance (Bureau) contact information for residents' use. Findings include: During the initial tour on 3/8/10 at 9:05 AM, it was noted the contact information for the Bureau was not posted with the contact information for other agencies acting as residents' advocates.	F 168		4/12/10

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F 168	Continued From page 7 On 3/10/10 at 10:05 AM, the Administrator confirmed the contact information for the Bureau was not posted in the facility.	F 168		
F 223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on resident interview, policy and procedure review, facility document review and staff interview, the facility failed to recognize and follow up on an allegation of possible abuse for 1 of 24 sampled residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 5/22/09, with diagnoses of back pain, paralysis agitans, diabetes, history of fractured clavicle and vertebra, generalized pain, muscle weakness and drug (opioid) dependence. The resident had a peripherally inserted central catheter (PICC) line in place at the time of admission. The PICC line had been changed, with placement confirmed by x-ray on 2/17/10. Doctor's orders included routine PICC line dressing changes. The PICC line continued to be used and maintained for pain	F 223		4/12/10

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F 223	Continued From page 8 medication administration purposes. On 3/8/10 at 2:40 PM, an interview with Resident #3 revealed a concern with rough treatment during PICC line dressing changes. The resident indicated on multiple occasions one particular wound care nurse would "rip off the PICC line dressing." The resident stated after he had asked the nurse to be careful, the same rough treatment continued. The resident stated when the same rough treatment continued, he then went to the Director of Nurses (DON) and reported the situation. The resident indicated he had received the same dressing changes by two other wound care nurses during this same period and did not have any problems. The resident showed his pictures of the PICC line site during the time he indicated he had received the rough treatment were reviewed. The pictures indicated the area in question was bright red, irritated, with possible areas of denuded skin indicative of where a dressing had probably been removed. The resident stated when he met with the DON he was told "he just had sensitive skin." The resident indicated he felt his concerns were simply dismissed and was not aware of any follow up by the facility. On 3/9/10 at 10:20 AM, an interview with the DON was conducted. The DON recalled Resident #3 coming to her with his concerns and confirmed she had told him he had sensitive skin. The DON indicated she had spoken with the wound care nurse, but was not concerned because she had never had any problems with the nurse, and the nurse had always done a good job. The DON admitted, at the time she had not thought or considered the situation as possibly an allegation of abuse and did not follow up with an	F 223		

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F 223	Continued From page 9 investigation or report. Review of the facility's incident reports confirmed no follow up, investigation, or reporting to State authorities had been done. Review of the facility's policy and procedure titled "What You Need To Know - Abuse Prohibition" dated 2004, indicated the facility was to conduct a prompt investigation of any allegation received of suspected abuse, neglect or misappropriation of property or funds. The policy also indicated that staff members were to identify and assess suspected or alleged reports of abuse focusing on objective and observable evidence, such as bruising and statements of witnesses regarding occurrences or patterns or trends of potential abuse. Component V of the policy indicated investigations were to be prompt, comprehensive and responsive to the situation and contain founded conclusions. Component VII of the policy outlined that all alleged violations concerning abuse were to be reported immediately to the Administrator/Designee and other enforcement agencies including the State Survey and Certification Agency (Bureau).	F 223		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to promote an environment that enhanced resident dignity, by allowing 1 of 5	F 241		4/12/10

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unsampled residents to sit in a public area with a spoon sticking out of his mouth (Resident #27), by not providing the proper receptacles for residents consuming milk products in 2 of 2 meal observations, and by not positioning 1 of 5 unsampled residents at the dining room table in a manner which promoted eating in a comfortable manner (Resident #25).

Findings include:

Resident #27

Resident # 27, an unsampled resident, had experienced a traumatic brain injury, and needed to be fed by staff members. During the noon time meal, on 3/9/10, the resident was observed in the assisted dining room being fed by a certified nursing assistant (CNA). Resident #27 exhibited the tendency to bite down on the feeding utensil or his milk carton. The CNA was overheard to say to the resident, "don't bite down" on several occasions. It was then observed that the CNA would have a difficult time pulling the spoon back out of Resident # 27 's mouth. At one point, after unsuccessfully attempting to remove the spoon while the resident was biting down, the CNA let go of the spoon and sit there staring at the resident. Resident #27 was in view of the other residents and staff, sitting with a spoon sticking out of his mouth. His appearance was undignified and bordered on being comical. After several minutes, the CNA reached over and removed the spoon from Resident #27 's mouth.

It was observed on two occasions (3/9 and 3/10/10) in both dining rooms that residents, who were served milk and milk supplements, were not given glasses in which to pour the milk or given

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F 241	Continued From page 11 straws to place into the milk cartons. The cartons were opened and the residents drank directly from the carton. When staff were asked about the absence of glasses and straws, they replied that they could get glasses and straws if needed but they had never used them. In a random interview with a resident in the dining room, he responded that it would be easier to drink milk from a glass. All other beverages, juices and water, came from the kitchen in glasses. Resident #25 On 3/9/10 during a lunch time meal observation in the Sunflower dining room, Resident #25 was observed positioned parallel to the table in his wheelchair. Due to the position the resident was in, the resident was observed having to twist sideways while eating his meal. One licensed staff member and two nursing assistants were in the room assisting other residents. A majority of time the meal was observed the licensed staff member was seated in view of the resident. None of staff members were observed to approach the resident and offer to appropriately position the resident at the table. Following the meal observation, Resident #25 was interviewed. The resident stated he is "frequently positioned sideways at the table, but would prefer to be correctly seated at the table facing his meal." The resident indicated staff were busy so he just "went with the flow," and did not want to cause problems by asking to be repositioned.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		4/12/10

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A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:
Based on observation and resident interview the facility failed to provide bathroom accommodations when a resident's bathroom was in use during dialysis treatments for 1 of 24 residents (Resident #3).

Findings include:

Resident #3

Resident #3 was admitted to the facility on 5/22/09, with diagnoses of back pain, paralysis agitans, diabetes, history of fractured clavicle and vertebra, generalized pain, muscle weakness and drug (opioid) dependence. The resident was alert, oriented, independent in his decision making and required minimal assistance with his activities of daily living, which included grooming and toileting. During the survey period (3/8/10 to 3/11/10), on several occasions, the resident was observed maneuvering himself in his motorized wheelchair/scooter into the bathroom. The resident was observed using the bathroom to wash his face, comb his hair and empty his urinal in the toilet.

On 3/8/10 at 2:40 PM, an interview with Resident #3 revealed a concern with the availability of the

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bathroom when dialysis was provided in the adjoining room. The resident explained when the bathroom was tied up, while the resident in the adjoining room is receiving in house dialysis, which happened several hours at a time, several times a week, he was unable to use his bathroom. The resident indicated when the bathroom was tied up (with the dialysis equipment) he had to wait until the bathroom was available. The bathroom was shared by an adjoining room, with double occupancy in each room.

On the afternoon of 3/10/10, an observation of in house dialysis was made in a room across the hallway from Resident #3's room. This room had double occupancy and shared a bathroom with an adjoining room. Interview with the dialysis technician revealed the dialysis was scheduled to run for three hours. This particular resident received dialysis three time a week. Accompanied by the technician, the water hook up and disposal lines were discussed and observed. Both hook up and disposal lines were similar in size and shape of a garden hose. The hook up and disposal lines, ran from the dialysis machine (which was at the bedside), across the floor and into the bathroom. The water hook up line ran across the bathroom floor in front of the sink and was connected to an adaptor below and to the side of the sink. The disposal line ran across the bathroom floor and into the toilet. The bathroom would not not have been accessible by a wheel chair or motorized scooter. While the sink may have been accessible to staff or an ambulatory resident, the hook up and disposal lines presented safety concerns. Due to the disposal line running into the toilet the toilet was not available for use.

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F 246	Continued From page 14 The facility did not have a designated room for dialysis. There were four residents in the facility who were receiving in house dialysis treatments.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and interview, the facility failed to ensure that 4 of 24 residents who spent most of their time in their rooms, were provided with activities which focused on their interests and followed their care plans (Residents #7, #21, #10 and #12). Findings include: Resident #7 Resident #7 was admitted to the facility on 11/12/09, with re-admission on 12/30/09. Diagnoses included diabetes, abnormal weight loss, gastroesophageal reflux disease, attention to gastrostomy, nonorganic psychosis, and depressive disorder. During the survey period, the resident was observed to remain in her bed all day and received meals in her room. In an interview on 3/8/10 at 3:15 PM, the resident communicated that she felt too weak to lift herself up in bed, and that she enjoyed having staff come into her room and talk with her.	F 248		4/12/10

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Review of the Activities care plan revealed that Activity staff were to provide room visits three times a week, focusing on the resident's interests of social stimulation and music. The Individual Resident Daily Participation Record for the months of February and March, completed by the Activities Director indicated that Resident #7 watched TV every other day and had "reality orientation" every other day. There was no indication or documentation that music was a part of the visits. There was a TV in the resident's room, but it was not hooked up to cable and could only be used for videos.

Resident # 21

Resident #21 was originally admitted to the facility on 10/13/06, with re-admission on 10/6/09. Diagnoses included debility, nonorganic psychosis, anxiety, and hypertension. The resident communicated in Spanish and had no family. During the survey period, the resident was observed to remain in her bed all day and receive meals in her room.

Review of the Activities care plan revealed that Activity staff were to provide room visits three times a week, focusing on the resident's interests of Spanish music, rubbing lotion on her hands, and eating ice cream or pudding. According to a note documented by the Activities Director on 10/8/09, "She seems to enjoy Spanish music; she has periods of crying out and snacks from the kitchen tend to calm her down for a short time; refer to activity care plan." The Individual Resident Daily Participation Record for the months of January and February 2010, indicated that Resident #21 watched TV every other day

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and had "sensory orientation" every other day. There was no indication on the Participation Record that music or eating was a part of the room visits.

Resident #10

Resident #10 was admitted to the facility on 2/1/10, with diagnoses that included hemiplegia, cerebral-vascular accident, Parkinson's and dementia. Initial assessments indicated that Resident #10 required tube feedings, total care, and was bedfast. Resident #10's ability to communicate was assessed as minimal, and non-verbal.

An interview with Resident #10's wife revealed Resident #10 had been a radio announcer and enjoyed all types of music. There was no radio in the room. Resident #10's wife acknowledged there was no radio.

Review of the activities care plan revealed Activity staff were to provide room visits three times a week for social, sensory stimulation, and to turn on music during room visits.

Random observations during the four days of the survey revealed there was no music playing while Resident #10 was in the room.

Resident #12

Resident #12 was a 101-year-old resident, admitted on 8/5/05, with diagnoses including diabetes, attention to gastrostomy tube, and dysphagia. Documentation in the resident's

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F 248	Continued From page 17 record indicated that Resident #12 required tube feedings, total care, and was bedfast. Resident #12's ability to communicate was assessed as minimal, and non-verbal. Review of the activities care plan revealed Activity staff were to provide room visits three times a week for social, sensory stimulation, and provide music as the resident had been a musician. Random observations during the four days of the survey revealed there was no music playing while Resident #12 was in the room. There was no radio noted in Resident #12's room during the observations. On 3/11/10 at 9:15 AM, the Activites Director was told of the observations. The Activity Director stated that there was a radio on the facility's room visit cart, and sometimes those visits took place on the weekends.	F 248		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review, and review of facility policy, the facility failed to provide the necessary and needed social services for 1 of 24 residents who made suicidal statements (Resident #16), failed to develop a policy for determining a	F 250		4/12/10

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responsible party for 2 of 24 residents who could not make reasonable decisions (Residents #4 and #21), and failed to follow the facility policy for filing a grievance for 1 of 24 residents (Resident #23).

Findings include:

Resident #4

Resident #4 was admitted to the facility on 11/13/09 with diagnoses that included post intracranial hemorrhage, debility, hypertension, depressive disorder and anxiety. She had a gastrostomy tube.

Review of the resident record revealed that the face sheet indicated that the resident was responsible for herself. The facility's consent for treatment was unsigned. The form contained a note, "public guardian applied for 1/4/10." Also in the record were informed consents for the psychoactive medications, Haldol, Ambien and Lexapro. The consents did not have a signature from the resident or the responsible representative. These forms also indicated that a public guardian was pending. There was no documentation in the record as to the status of the guardianship. In an interview with a social worker, on 3/8/10 at 1:15 PM, she indicated that guardianships could take six months to a year to be approved. She further added that she was not aware of any facility policy determining who was to be the responsible party or how informed consents could be obtained until a guardianship could be approved.

Resident #16

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Resident #16 was admitted to the facility on 2/10/10 and discharged on 2/22/10. The resident's diagnoses included hypertension, chronic obstructive pulmonary disease and gastric reflux and had been admitted following a fall which resulted in pelvic fractures.

Review of the social services notes in this closed record revealed an entry dated 2/5/10 from a social worker. The entry stated that the facility receptionist had been notified by another facility that Resident #16 had telephoned them stating she wanted to get out of the facility and that she had told her daughter that she would kill herself. The social worker documented that she spoke with Resident #16 who denied having a plan for suicide. The resident further stated that she didn't get enough therapy and that she didn't like the food. The social worker's response was that she would start discharge planning.

An interview was conducted on 3/10/10 at 2:00 PM with the Director of Nurses (DON) who was the DON at the time of the documentation. She denied any knowledge of the resident's suicidal statement. She added that the social worker was no longer employed at the facility.

Interviews were conducted with the Regional Director of Social Services and the New Director of Social Services on 3/10/10. Both employees agreed that the social worker did not proceed appropriately for a resident who had made a suicidal threat.

A facility policy was presented entitled "Suicidal Precautions Management", dated 7/2/2009. The policy stated the following :

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F 250	Continued From page 20 Immediate interventions for a resident voicing suicidal thoughts A. Were to notify the physician, psychiatrist/counselor/psychologist and family immediately, if the resident did not have a psychiatrist, then a referral was to made at that time. B. Pursuant to physicians orders, suicide precautions are implemented immediately. (if the physician could not be reached in a reasonable time, the nurse in charge may implement suicide precautions) C. Medical intervention commences within 24 hours. D. Administrator, DON, and Social Services Director are notified and visit with the resident to determine if adequate safety is being provided. E. Staff visually observes resident every 15 minutes while on suicide precautions. F. Remove clothing from resident's room that can possibly contribute to self injury. G. Knives and forks are removed from tableware. H. Light cord is removed from the room. I. Resident is placed in private room if possible. J. Medication nurse observes resident swallowing all medications. K. If available a wanderguard is placed on the resident. L. Door is to remain ajar at all times M. A minimum of two staff escort resident to outside appointments. N. Nurses document every shift O. A physician's order is required to discontinue suicide precautions. Follow-up interventions included the development of behavioral interventions in the Care Plan,	F 250		

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provide ongoing support and reassurance, resident to continue to attend psychological appointments until formally discharged, attempt to set up a suicidal contract.

The social worker failed to take the proper precautions for Resident #16's safety and psychological well being by not following the facility policy and by discharging the resident without ascertaining her mental well being.

Resident #23

Resident #23 was admitted to the facility on 7/17/09, with primary diagnoses that included diabetes, asthma, venous insufficiency and lymphedema.

Review of the clinical record revealed that on 2/4/10, the Social Worker documented she had received a call from the Aging and Disability Services Division (ADSD), regarding Resident #23. ADSD indicated Resident #23 expressed concern that someone was "listening in on her cell phone."

The social worker documented that she did interview Resident #23 who alleged staff stood outside her room talking about taking pictures of her (Resident #23's) "fat belly." Resident #23 also alleged staff "bought snacks received in a recent package addressed to an unidentified resident."

The Social Worker documented the Director of Nursing (DON) had been informed of Resident #23's statements. The Social Worker documented the ADSD was notified.

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A review of the February and March 2010 grievance and complaint logs revealed there had been no grievance form filed regarding Resident #23's concerns.

An interview with the DON on 3/11/10, confirmed there was no record of the reported grievances.

Resident #21

Resident #21 was originally admitted to the facility on 10/13/06, with a current re-admission date of 10/6/09. Diagnoses included debility, nonorganic psychosis, depressive disorder, and hypertension. The annual minimum data set (MDS) dated 1/7/10, indicated that the resident's cognitive skills for daily decision-making were moderately impaired. Social Service notes revealed that the resident communicated in Spanish and had no family.

Review of the resident's record revealed that the Consent for Treatment form, dated 10/13/06, was unsigned and included the statement "Patient unable to sign due to confusion secondary to dementia; pending public guardian." Consent forms for psychotropic medications were also unsigned as of 3/8/10, and had the statement "pending public guardian" written on them.

In an interview with the Social Services Regional Director on 3/10/10 at 8:10 AM, the employee provided documentation showing that the facility had made a referral for Resident #21 to the Clark County Public Guardian's Office on 5/29/08. Between May and July of 2008, progress notes indicated that the facility followed-up on providing requested information from the Public Guardian's

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F 250	Continued From page 23 Office. The record lacked documented evidence of further communication between the facility and the Public Guardian's Office after 7/2/08. The Regional Director confirmed that the resident still did not have a public guardian. The Director of Nursing (DON) acknowledged that the facility did not have a policy pertaining to a circumstance whereby a resident did not have a legal guardian and was unable to sign treatment and medication consent forms.	F 250		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed, to provide a safe and clean environment for 2 of 24 sampled residents (Residents #18, #9), and to provide a homelike environment for all facility residents. Findings include: Resident #18 On the morning of 3/10/10, while visiting with Resident #18 in her room, observation of multiple dried brown spots, consistent with a formula or other tube feeding product, was observed on the ceiling tiles above the resident's bed. Also noted was a torn ceiling tile by the ceiling vent near the resident's window. The wall nearest to the	F 252		4/12/10

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F 252	Continued From page 24 resident's bed had numerous tack holes in the wall. An unframed picture of the resident and her family, which had a tack hole in the top, was creased, bent and laying on top of a dresser out of the resident's view. Resident # 9 A random observation in Resident #9's room at 10:00 AM on 3/9/10, following an interview with the resident revealed a plastic bag on the floor, at the head of the bed. The bag was tied. The plastic was not opaque. A soiled incontinence pad was visible through the plastic. Resident #9 acknowledged that she had required her incontinence pad to be changed at the change of shift (nights to days), approximately three hours ago. Observations of the Lilac Room (the assisted dining room), on several occasions from 3/8-3/11/10, revealed multiple pieces of furniture including sofas and easy chairs "stored" at the end of the dining area. The furniture was not arranged so that it could not be utilized for sitting. The presence of the furniture detracted from the appearance of a comfortable home like environment for the dining area.	F 252		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change	F 274		4/12/10

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means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a comprehensive assessment was conducted for 1 of 24 residents who had a significant change in physical and mental status (Resident #8).

Findings include:

Resident #8

Resident #8 was admitted to the facility on 12/29/09, with diagnoses including dysphagia, gastrostomy tube (g-tube), chronic obstructive pulmonary disease, congestive heart failure, depressive disorder, hypertension, gastroesophageal reflux disease, diabetes, and debility.

The admission Minimum Data Set (MDS), dated 1/5/10, indicated that the resident's cognitive skills were severely impaired, and that he had total dependence with eating, as he required all of his nutrient needs from his g-tube. Record review revealed that the resident began an oral diet, in conjunction with his enteral nutrition, on 2/9/10. On the resident's Activities of Daily Living (ADLs) tracking form, it was noted that from 2/12/10, the

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F 274	Continued From page 26 resident's eating ability improved from a level 4 (total dependence) to a level 2 (limited assistance). Review of the Nurse's Notes in Resident #8's record revealed the following documentation: 2/19/10 - alert and communicating with staff; 2/21/10 - alert and cooperative; 2/25/10 - up in wheelchair to eat in dining room for meals with restorative aide (RA), appetite is good; 2/26/10 - alert and able to make all needs known; 3/7/10 - D/C (discontinue) tube feeding secondary to good oral intake at meals. In an interview with the unit nurse manager on 3/10/10 at 8:45 AM, the nurse related that the resident's ADLs and decision-making skills had begun to significantly improve in late January. On 3/10/10 at 9:00 AM, the MDS Coordinator was interviewed. The employee explained that whenever a resident's abilities significantly improved or declined, she would be notified by Nursing, and a new assessment would be conducted within two weeks. The MDS Coordinator stated, "For some reason it wasn't brought to my attention. I wasn't in the loop."	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		4/12/10

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F 278	Continued From page 27 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on resident record review, the facility failed to ensure the accuracy of the Minimum Data Set for 1 of 24 residents due to the assessment being completed before the Assessment Reference time frame had expired (Resident #17). Findings include: Resident #17 Resident #17 was admitted on 7/26/04. Diagnoses included Alzheimer Disease, hypertension, anxiety and psychosis. She was on Hospice. Review of the resident record revealed a	F 278		

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F 278	Continued From page 28 Minimum Data Set (MDS) labeled as a quarterly assessment with a completion date of 12/9/09. The Assessment Reference Date or the last day of the MDS observation period was also documented as being 12/9/09. The accuracy of the MDS could not be guaranteed as the MDS was completed before the last day of the observation period ended.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure the results of the comprehensive assessment were used to develop or follow the resident's comprehensive	F 279		4/12/10

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care plan for 9 of 24 residents (Residents #10, #11, #5, #6, #16, #18, #15,#12, #14).

Findings include:

An interview with the Regional Director of Social Services was conducted on 3/9/10. It was confirmed that social services were to include a discharge plan upon admission for all residents. This discharge care plan was to be initiated upon admission and individualized for each resident.

Resident #10

Resident #10 had been admitted on 2/1/10. There was no social service/discharge care plan. An admission assessment by the social worker indicated the discharge plan was that long term care was anticipated. Resident #10 had been seen by the social service department three times in February, 2010. This documentation indicated Resident #10 required full 24/7 care and the family would be unable to provide the care needed.

An interview with the Minimum Data Set (MDS) coordinator on 3/9/10, confirmed that the care plans were preprinted with specific problems. The MDS coordinator acknowledged the care plans were not adjusted to reflect a resident's specific needs.

Resident #11

A review of Resident #11's care plan with the MDS coordinator was conducted on 3/10/09. Resident #11 was on anticoagulants but also had a stage four pressure ulcer on her coccyx. The MDS coordinator acknowledged that due to the

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degree of the wound, the risk of bleeding was increased with the anticoagulant therapy. The MDS coordinator acknowledged this information was not included on Resident #11's plan of care.

Resident #5

Resident #5 was admitted on 3/1/09. Diagnoses included dementia, dysphagia, convulsions, diabetes type II and aphasia. She received a honey thickened liquid diet and was prone to constipation.

The resident's record contained a care plan for altered nutritional status. The second problem identified was inadequate oral intake with a goal of meeting the hydration needs. There was no approach as to how the oral intake would be measured or what steps would be taken to avoid an inadequate fluid intake.

Three different diets were indicated in the approaches for the altered nutritional status. None of the diets had been resolved and it was not possible to determine from the care plan which diet was currently ordered for Resident #5.

Also present in the record for Resident #5 was a care plan for constipation. The approaches indicated to: 1) give meds as ordered, if no B.M, and 6) after three days, perform a bowel assessment. The orders indicated that Milk of Magnesia (MOM) 30ml (milliliters) prn (as needed) daily was to be given. If the MOM was not effective, a rectal suppository could be given every three days if needed. A flowsheet for February 2010 indicated that Resident #5 did not have a bowel movement (BM) from 2/14 until

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2/19/10 and from 2/20 until 2/24/10. The Medication Administration Record (MAR) for February 2010 did not record the administration of any MOM for the month of February. The MAR did indicate that the rectal suppository had been given every three days even on the days that the resident had a BM. There was no documented evidence that a bowel assessment had been performed when more than three days had lapsed without a BM. The care plan for constipation had not been revised to reflect the care given to Resident #5 for constipation.

Resident #6

Resident #6 was admitted to the facility on 10/21/05 with diagnoses that included post effects of a cerebral vascular accident, aphasia, chronic obstructive pulmonary disease, anxiety and psychosis. He had a gastrostomy tube, receiving a can of Jevity six times daily and water flushes, otherwise he received nothing via mouth.

Resident #6's care plan for altered nutrition and hydration was very generic and non specific. The Rap/Problem/Need did not indicate if the G-tube feeding was for full nutrition and hydration or partial nutrition and hydration. One of the goals documented was the resident was to be weaned from the G-tube over the next 90 days. Resident #6 had been fed via the G-tube for nearly five years and there was no documentation indicating that he would ever be able to resume oral feedings and hydration. The approaches were "canned" and did not show any individualization.

Resident #16

Resident #16 was admitted to the facility on

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2/10/10 and discharged on 2/22/10. The resident was diagnosed with hypertension, chronic obstructive pulmonary disease and gastric reflux and was admitted following a fall which resulted in pelvic fractures.

Review of the social services notes in this closed record revealed an entry dated 2/5/10 from a social worker. The entry stated that the facility receptionist had been notified by another facility that Resident #16 had telephoned them stating she wanted to get out of the facility and that she had told her daughter that she would kill herself. The social worker documented that she spoke with Resident #16 who denied having a plan for suicide.

A facility policy was presented entitled "Suicidal Precautions Management", dated 7/2/2009. The policy stated the following :

Follow-up interventions included the development of behavioral interventions in the Care Plan.

There was no evidence that this significant care plan had been developed.

Resident #18

Resident #18 was admitted to the facility on 1/27/10 with diagnosis including end stage renal disease, diabetes type II, osteomyelitis, status post amputation of the toe, hypertension, generalized pain, congestive heart failure, insomnia and depression.

The admission Minimum Data Set (MDS) with the assessment reference date of 2/2/10 and the

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Resident Assessment Protocol (RAPs) triggered as a result of the MDS, indicated a care plan should have been developed to address dehydration/fluid maintenance. Review of the resident's care plan failed to reveal a care plan for dehydration/fluid maintenance.

Resident #15

Resident #15 was admitted on 2/22/10, with diagnoses including paraplegia, Stage IV pressure ulcer, and osteomyelitis. On 2/22/10, a Registered Nurse (RN) documented on the initial assessment that Resident #15 had a Foley catheter in place.

During the time of the assessment the RN developed an "Interim Plan of Care" for Resident #15's catheter. According to the plan, the staff were to, "encourage fluids and assess for continued use." The goal of the interventions was, "No Complications." There were no specific interventions listed to direct the staff on what measures to take to provide care with regards to the catheter to obtain the goal of the care plan.

On 3/11/10 at 8:45 AM, The Director of Staff Development confirmed the "Interim Plan of Care" for Resident 15's catheter did not provide specific interventions to guide the nursing staff in caring for the resident's Foley catheter.

The facility's policy titled "Comprehensive Care Plan" with an original date of 3/2006, indicated an initial care plan was to be developed after the completion of the discipline specific assessment.

On 2/23/10, the facility developed a care plan with

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regards to Resident #15's pressure ulcer. One approach was documented as, "provide pressure relieving device for bed and wheelchair." On 3/10/10 at 2:10 PM, Resident #15 was observed up in a wheelchair in the therapy room. There was no pressure relieving cushion on the resident's wheelchair.

On 3/11/10 at 11:00 AM, the Director of Nursing confirmed there was no pressure relieving cushion on Resident #15's wheelchair.

Resident #12

Resident #12 was admitted on 8/5/05, with diagnoses including diabetes, attention to gastrostomy tube, and dysphagia. Documentation in the resident's record indicated that Resident #12 required tube feedings, total care, and was bedfast. Resident #12's ability to communicate was assessed as minimal, and non-verbal.

The facility developed a care plan with regards to Resident #12's risk for skin breakdown. One approach indicated the resident was to have heel protectors on while in bed. On 3/9/10 at 9:20 AM, the Certified Nursing Assistant explained the care provided to Resident #12. The employee did not mention the use of heel protectors. On 3/9/10 at 9:40 AM, Resident #12 was in bed, in the supine position. There were no heel protectors on the resident's feet. The resident's heels were in contact with the mattress.

On 3/9/10 at 11:55 AM, a Licensed Practical Nurse identified as responsible for Resident #12's care indicated he was unaware of the approach for heel protectors.

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F 279	Continued From page 35 Resident #14 Resident #14 was admitted on 2/23/09, with diagnoses including dysphagia, carotid artery occlusion, and muscle weakness. On 3/9/10 at 12:30 PM, Resident #14 was observed to eat 60% of the lunch meal. The resident stated, "I can't eat anymore." The facility developed a care plan in regards to Resident #14's risk for weight loss. One of the approaches was to monitor intake amounts. A review of the Activity of Daily Living sheets for January 2010 meal intake revealed for 1/21, 1/25, and, 1/28/10, the breakfast and lunch intakes were not documented. The dinner intakes were not documented for 1/5, 1/7, 1/14, 1/28, 1/30, and 1/31/10. For the month of February 2010, the breakfast and lunch intakes were not documented for 2/11, 2/14, and 2/18/10. On 3/10/10 at 8:15 AM, a Certified Nursing Assistant stated that each meal intake was to be documented on the form. Documentation on the weight record for Resident #14 indicated from 1/4/10 through 3/7/10, Resident #14 lost 5.2 pounds.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		4/12/10

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within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on policy review and interview, the facility failed to ensure that residents or their legal guardians were invited to participate in quarterly care planning conferences for 2 of 24 sampled residents (Residents #3, #26), and for 10 of 10 residents who had participated in the survey's group interview.

Findings include:

During a group interview on 3/9/10 at 11:00 AM, ten alert and oriented residents were asked if they ever participated in meetings in which interdisciplinary staff planned their medical and nursing care. No one in the group indicated they attended, or were invited, to the meetings.

On 3/10/10 at 9:30 AM, the regional Director of Social Services was interviewed. The employee acknowledged that residents or their legal guardians were not consistently invited to the resident's quarterly care planning meetings, and

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that there was no system in place to document whether or not an invitation to the meetings was made either by phone or by letter.

Resident #3 and Resident #26

On the afternoon of 3/10/10, in the course of conversation with Resident #3 and #26, both residents indicated they were not aware that the facility conducted care conferences and had not been invited to participate in the planing of their care or to attend care conferences.

Resident #3 had been admitted to the facility on 5/22/09. Review of the resident's record failed to reveal evidence that the resident and been invited or attended any conference since his admission.

Following the discussion with the two residents, an interview with the facility's social workers was conducted.

One of the social workers, who indicated being employed with the facility since January 2010, revealed she was not familiar with the facility's policy on inviting residents or their responsible parties to participate in the development of the residents' plan of care or to attend care conferences. The employee admitted, in her time at the facility, residents or resident's responsible parties had not been offered the opportunity to attend care conference.

The other social worker, who had just started with the facility on 3/8/10, indicated she had not yet had the opportunity to review the facilities policies. The social worker indicated she had long term care experience and that it was her experience to involve residents in their care plans

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F 280	Continued From page 38 and to extend the invitation to residents and residents' responsible parties to participate in the interdisciplinary care conference. The social worker researched and submitted the facility's policy the following day. On 3/11/10, the facility's Social Services Policies and Procedures, titled "Comprehensive Care Plan," dated 3/2006, were reviewed. The policy and procedures indicated the following: 1) The care plan was to be utilized to promote resident and family involvement in planning care 2) Social Services Staff was to notify the resident and his or her legal representative prior to each care plan meeting and to invite them to attend the meeting in order to solicit their input 3) If the resident or their legal representative was unable to attend, the care plan was to be reviewed with the resident or their legal representatives and their response were to be documented 4) All participants in the Care Conference were to sign the the Care Plan Conference Notes In the materials provided for review, there was also a facility form letter which explained the care plan meetings and included an invitation to participate in the care plan meeting.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, policy review, observation, and record review, the facility failed to ensure	F 281		4/12/10

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licensed nursing staff followed standard of practices regarding medication administration, securing medication, and following physician orders as stated in the Nevada Nurse Practice Act for 6 of 29 residents (Resident #9, #5, #6, and #23, #28 and #29). The facility also failed to ensure continuous supervision was provided during dialysis administration for 1 of 24 residents (Resident #18).

Findings include:

An interview with the Director of Nursing on 3/9/10, revealed the facility used the Nevada Nurse Practice Act as the Standard of Practice for nursing staff.

The Nevada Nurse Practice Act defined the duties of the registered nurse and included:
632.212 (h) maintaining accountability in the delegation of care
632.212 (i) administering medications and carrying out treatments which were properly authorized.

Nursing standards of practice did not allow licensed practical nurses (LPNs) to make decisions regarding changing routes or forms of medication.

The facility policy for medication administration described the procedure:
"(2) Medications are administered in accordance with written orders of the attending physician and (18) Prior to administration, the medication and dosage schedule on the patient's MAR is compared with the medication label." The facility procedure indicated this information should be checked at least three times during the

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medication preparation. If there was a discrepancy the physician's orders were to be checked.

Review of the facility policies regarding medication administration specified:"page 3, (20) (F) The need for crushing medications is indicated on the patients MAR/TAR (medication administration record/treatment administration record) so that all personnel administering medications is aware of this need and the Consultant Pharmacist can advise on safety and alternatives, if appropriate, during MAR/TAR reviews."

This policy was presented in a training on 2/4/10. This inservice was attended by 16 licensed nursing staff. The attendance sheet was signed by the LPN who was observed during medication pass on 3/9/10.

The nursing staff failed to follow physician orders for the following residents.

Resident #9

Resident #9 was admitted to the facility on 8/20/09, with diagnoses that included diabetes. Clinical record review revealed that on admission, Resident #9's physician orders included the following:

A fingerstick blood sugar (FSBS) was to be done before each meal and at hour of sleep (9:00 PM). Novolin R (insulin, regular human) sliding scale was to be administered for the following FSBS results.
150 - 200 to receive 2 units regular insulin subcutaneous

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F 281	Continued From page 41 201 - 250 to receive 4 units regular insulin subcutaneous 251 - 300 to receive 6 units regular insulin subcutaneous 301 - 350 to receive 8 units regular insulin subcutaneous 351 - 400 to receive 10 units regular insulin subcutaneous If FSBS was less than 60, administer 1/2 ampule of D50 intravenously If FSBS was greater than 400, notify physician. Review of the physicians' orders revealed that on 11/30/09, the physician changed the 9:00 PM FSBS coverage to be 1/2 of the ordered sliding scale amount. This meant that if the 9:00 PM FSBS was 178, Resident #9 was to receive 1 unit of Novolin R instead of 2, and so on. Review of the physician recap orders for November and December, 2008 and January, February and March, 2010 did not reflect the change in the sliding scale orders. The medication administration records (MAR) for the months of December 2009, and January, February and March 2010, revealed the original order had not been discontinued and the sliding scale rewritten to include the new change. It was also observed that although the change was included in the MAR, it was not on the same page as the original sliding scale order. Review of the sliding scale coverage records in the MAR revealed the licensed nursing staff continued to administer the full dose of sliding scale insulin coverage at 9:00 PM for the past four months. Review of the recap orders for the past five months revealed that Resident #9 continued to have conflicting anticoagulant level lab orders	F 281		

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without evidence the physician was contacted. An order on 9/17/09, for prothrombin levels three times a week lab work was changed to be done once a week on 10/21/09. The physicians' recap orders were not changed until February 2010.

Review of Resident #9's record revealed that a peripherally inserted central catheter (PICC) was present on 9/11/09 and discontinued on 12/22/09. The physician's orders for January, February and March 2010, continued to contain that the PICC line was to be flushed with saline every shift and flushed with heparin and saline after any medication.

Resident #23

Resident #23 had been a resident at the facility since 7/17/09, with diagnoses that included diabetes, neuropathy and insomnia.

Review of the interim orders revealed the Neurontin had been increased to 400 mg three times a day on 2/25/10. On 2/26/10, an interim order was received for Risperdal 0.25 mg to be given twice a day and 0.5 mg to be given at bedtime, following a psychiatric evaluation

Review of Resident #23's recap physician orders for 3/1/10 - 3/31/10, revealed an order dated 10/16/09, for Neurontin 300 milligrams every eight hours. The March recap did not contain the change of dose for Neurontin or the addition of Respirdal.

Review of Resident #23's MAR revealed that the March MAR did not include the increased dose of Neurontin, nor the Respirdal order. The MAR did have documentation that indicated nursing staff

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F 281	Continued From page 43 administered Neurontin 300 mg every eight hours. Review of Resident #23's medication packets revealed a blister pack identified as Neurontin 400 mg, one capsule, to be given to Resident #23 three times a day. This review also revealed a blister pack identified as Risperdal 0.25 mg, one tablet to be given in the morning and afternoon and a blister pack identified as Risperdal 0.50 mg, one tablet to be given at bedtime. These blister packs had evidence that medication had been dispensed. An interview on 3/11/10, with the Licensed Practical Nurse (LPN) who was the Unit Manager revealed that there was no evidence that licensed nursing staff followed correct procedure of medication administration, specifically: 1) Comparing the blister packs with the MAR to ensure correct patient, drug, route, dose, time regarding Resident #23. 2) Failed to follow the physician's orders regarding the sliding scale insulin administration for Resident #9. Resident # 28 An interview on 3/9/10, with the LPN performing medication pass revealed Resident #28 required medication administration through his gastrostomy tube, because although Resident #28 was able to swallow a mechanical soft diet he had difficulty swallowing fluids. Resident #28 gestured "yes" to this comment. Review of the facility policies regarding medication administration specified: page 3,(20 F) "The need for crushing	F 281		

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medications is indicated on the patient's MAR, so that personnel administering medications are aware of this need and the Consultant Pharmacist can advise on safety and alternatives if appropriate during MAR reviews."

On 3/9/10, Resident #28 was observed receiving seven medications through the gastrostomy tube. These medications were five pills:
Aspirin chewable 81 milligrams (mg)
Omeprazole delayed release capsule 20 mg
Levitiracetam 500 mg
Oxybutain 5 mg
Topamax 50 mg
and two medications in liquid form.
Docusate 100 mg/10 cubic centimeters (cc)
Guaifenesin 100 mg/5 cc

The LPN altered their shape either by crushing or separating the capsules to be able to pass through the gastrostomy tube. The LPN did not prepare the medications with applesauce so they could be administered orally.

Review of the physician orders revealed that all of Resident #28's medications were ordered to be given orally. There were no physician's orders to indicate that these medications could be given by gastrostomy tube. The physician orders also specified the Docusate was to be a pill.

Review of the Medication Administration Record (MAR) revealed no documentation that Resident #28's medications were to be crushed and administered through the gastrostomy tube.

Review of Resident #28's clinical record revealed no evidence of communication by the facility to inform the physician of Resident #28's need to

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have medication crushed and administered through the gastrostomy tube. There was no evidence to reflect the facility had requested the Docusate to be changed to a liquid form.

Resident #29

Resident #29 was observed to receive medications during the the medication pass on 3/9/10, by the LPN. Resident #29 was to receive Aspirin 81 mg and Prilosec 20 mg as part of his medication regime. It was observed the LPN administered Aspirin 81 mg, enteric coated tablet and Prilosec Extended Release. The LPN stated that she gave the enteric coated Aspirin to Resident #29 because "if a resident can swallow a pill whole, enteric coated Aspirin was given, otherwise, chewable tablets are give. The LPN also stated the facility only had the extended release Prilosec available.

Review of the physician's orders for Resident #29 revealed the Aspirin was not ordered to be enteric coated. The Prilosec was not ordered as an extended release medication.

There was no evidence the physician was aware of this practice. The facility could not provide any policies that enteric coated Aspirin or extended release Prilosec could be substituted if not specified.

The facility policy allowed the medication cart to be unlocked during med pass, only if it was placed directly across the doorway of the room the nurse was in administering medications. The medication cart was required to be clearly visible and under the control of the personnel administering the medications.

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F 281	Continued From page 46 It was observed that from 8:30 AM through 9:30 AM, on 3/9/10, during medication pass observation with the LPN, the medication cart was left unlocked and unattended for periods of time lasting from five to 20 minutes. One instance, the medication cart was between two rooms, and angled allowing easy access to the unlocked drawers. During medication administration to a resident requiring gastrostomy access, the medication cart was placed across the doorway. This resident was located in the window bed. The LPN was unable to visually access the cart, as she was behind the privacy curtain, with her back to the door. Resident #5 Resident #5 was admitted on 3/1/09. Diagnoses included dementia, dysphagia, convulsions, diabetes type II and aphasia. She received a honey thickened liquid diet and was prone to constipation. The resident record contained an order dated 12/11/09 for Simvastatin 40 mg to be given at bedtime. A new order had been written on 12/30/09 changing the administration time to 5:30 PM. The change was not reflected on the Order Recaps or the MARs. The Medication Administration Records (MARs) for January and February 2010 recorded that Resident #5 had received the medication at bedtime. In an interview with a licensed practical nurse (LPN) on Station 1, she confirmed that the medication, Simvastatin, was being given to Resident #5 at 5:30 PM.	F 281		

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Also present in the record for Resident #5 were orders for the treatment of constipation. The orders indicated that Milk of Magnesia (MOM) 30ml daily as needed was to be given. If the MOM was not effective, a rectal suppository could be given every three days if needed. A flowsheet for February 2010 indicated that Resident #5 did not have a bowel movement (BM) from 2/14 until 2/19/10 and from 2/20 until 2/24/10. The Medication Administration Record (MAR) for February 2010 did not record the administration of any MOM for the month of February. The MAR did indicate that the rectal suppository had been given every three days even on the days that the resident had a BM. In an interview with an LPN on Station 1 on 3/9/10, she disclosed that she never gave the MOM because the resident had a severe problem with constipation and responded better to a Dulcolax suppository every three days. She acknowledged that the physician had not been notified for a change in the order.

Resident #5 had a diagnosis of Type II diabetes treated with a finger stick before meals and at bedtime. The fingerstick had a prescribed sliding scale insulin coverage based on the results of the fingerstick. Review of the flowsheet for January 2010 for Resident #5 revealed that on 1/4/10 at 11:30 AM, she had a fingerstick of 68. On 1/5/10 at 11:30 AM, her fingerstick was again 68. According to the sliding scale insulin coverage orders, the resident was to receive 1 amp of D50 (a dextrose solution) intravenous push for a fingerstick of less than 70. There was no evidence that the ordered medication was administered. In an interview with an LPN on Station 1 on 3/9/10, she disclosed that she had given the resident orange juice instead of the ordered D50. The physician had not been

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notified to change the order.

Resident #6

Resident #6 was admitted to the facility on 10/21/05 with diagnoses that included post effects of a cerebral vascular accident, aphasia, chronic obstructive pulmonary disease, anxiety and psychosis. He had a gastrostomy tube, receiving a can of Jevity six times daily and water flushes, otherwise he received nothing via mouth.

A review of Resident #6 orders for care revealed that he was receiving 1 can of Jevity tube feeding six times a day. The special instructions for the G-tube stated that the resident should be checked for residual every six hours. In an interview with a RN on Station 1 on 3/9/10, it was acknowledged that the order was in error, the facility policy was to check for residual prior to each tube feeding.

Review of the orders also revealed that the medications, Tylenol, Aspirin, ProSource, and Neurontin were ordered to be given orally, not via the G-tube. Resident #6 was to be given nothing by mouth.

Resident #18

Resident #18 was admitted to the facility on 1/27/10 with diagnosis including end stage renal disease, diabetes type II, osteomyelitis, status post amputation of the toe, hypertension, generalized pain, congestive heart failure, insomnia and depression. Physician's orders included dialysis treatments three times a week in the facility. The order specified the facility's

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contractor was to provide the resident's dialysis treatments.

On 3/10/10 at approximately 2:00 PM, Resident #18 was observed in her room with dialysis treatment in progress. The Dialysis Technician was in attendance at the time. The dialysis equipment and connections were observed and discussed with the technician, including the water and disposal lines that ran from the equipment into the bathroom. The technician indicated she had started the resident's dialysis shortly before this surveyor had arrived and that it would be running for three hours. The resident's lines and connection to the machine were also observed. The resident was being dialyzed via a IJ (internal jugular) Permacath. The technician accompanied this surveyor to the door way and looked down the hallway. The technician asked a staff member where the nurse was while continuing to look down the hall. This surveyor continued down the hall and around the corner just past the nurses' station where a fellow surveyor was met. When this surveyor and fellow surveyor turned to return to Resident #18's room, the technician was observed in the hall near the nurses' station. The nurses' station was approximately 50 to 60 feet away and well out of view of the resident's room. Upon seeing the surveyors the technician returned to the resident's room.

Following the technician back into Resident #18's room, the technician was asked why she had left the room while the dialysis was running. The technician simply indicated she was looking for the nurse. The technician was further interviewed regarding dialysis administration, resident monitoring before, during and after treatment. The technician indicated she was a certified

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F 281	Continued From page 50 dialysis technician, and had been working in the field in Colorado and Nevada for the past five years. Resident #18, who was also interviewed at the time, indicated she had been on dialysis for the past 3 years. At approximately 2:50 PM the survey team met with the Director of Nursing (DON) and the facility's Clinical Services Director (CSD) to discuss patient safety and concerns with the dialysis technician leaving Resident #18 unattended while dialysis was being administered. The DON and CSD agreed the resident should not have been left unattended and confirmed during dialysis treatments the dialysis technician was to be in attendance with the resident at all times. The DON confirmed there was another resident scheduled for dialysis, following Resident #18 treatment. Review of the facility's list of residents receiving dialysis, revealed there were four residents who received in house dialysis treatments at the facility which were provided by the facility's dialysis contractor. At 3:25 PM the Administrator, DON and CSD, presented an immediate plan of correction which was reviewed and approved by the survey team.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		4/12/10

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This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, observation and policy review, the facility failed to provide the needed services to attain or maintain the the optimum well being for 1 of 24 residents in administering medications at the prescribed times (Resident #5), following the orders of the physicians for treatment of constipation and low blood sugars for 1 of 24 residents (Resident #5), failing to follow facility protocol in checking placement of a feeding before each feeding for 1 of 24 residents (Resident #6), following physician orders for 2 of 29 residents (Residents #9, #23).

Findings include:

Resident #5

Resident #5 was admitted on 3/1/09. Diagnoses included dementia, dysphagia, convulsions, diabetes type II and aphasia. She received a honey thickened liquid diet and was prone to constipation.

The resident record contained an order dated 12/11/09 for Simvastatin 40 mg to be given at bedtime. A new order had been written on 12/30/09 changing the administration time to 5:30 PM. The change was not reflected on the Order Recaps or the MARs. The Medication Administration Records (MARs) for January and February 2010 recorded that Resident #5 had received the medication at bedtime. In an interview with a licensed practical (LPN) on Station 1, she confirmed that the medication, Simvastatin, was being given to Resident #5 at

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5:30 PM.

Also present in the record for Resident #5 were orders for the treatment of constipation. The orders indicated that Milk of Magnesia (MOM) 30ml daily as needed was to be given. If the MOM was not effective, a rectal suppository could be given every three days if needed. A flowsheet for February 2010 indicated that Resident #5 did not have a bowel movement (BM) from 2/14 until 2/19/10 and from 2/20 until 2/24/10. The Medication Administration Record (MAR) for February 2010 did not record the administration of any MOM for the month of February. The MAR did indicate that the rectal suppository had been given every three days even on the days that the resident had a BM. In an interview with an LPN on Station 1 on 3/9/10, she disclosed that she never gave the MOM because the resident had a severe problem with constipation and responded better to a Dulcolax suppository every three days. She acknowledged that the physician had not been notified for a change in the order.

Resident #5 had a diagnosis of Type II diabetes treated with a finger stick before meals and at bedtime. The fingerstick had a prescribed sliding scale insulin coverage based on the results of the fingerstick. Review of the flowsheet for January 2010 for Resident #5 revealed that on 1/4/10 at 11:30 AM, she had a fingerstick of 68. On 1/5/10 at 11:30 AM, her fingerstick was again 68. According to the sliding scale insulin coverage orders, the resident was to receive 1 amp of D50 (a dextrose solution) intravenous push for a fingerstick of less than 70. There was no evidence that the ordered medication was administered. In an interview with an LPN on Station 1 on 3/9/10, she disclosed that she had

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given the resident orange juice instead of the ordered D50. The physician had not been notified to change the order.

Resident #6

Resident #6 was admitted to the facility on 10/21/05 with diagnoses that included post effects of a cerebral vascular accident, aphasia, chronic obstructive pulmonary disease, anxiety and psychosis. He had a gastrostomy tube, receiving a can of Jevity six times daily and water flushes, otherwise he received nothing via mouth.

A review of Resident #6 orders for care revealed that he was receiving 1 can of Jevity tube feeding six times a day. The special instructions for the G-tube stated that the resident should be checked for residual every six hours. In an interview with a RN on Station 1 on 3/9/10, it was acknowledged that the order was in error, the facility policy was to check for residual prior to each tube feeding.

Resident #9

Resident #9 was admitted to the facility on 8/20/09, with diagnoses that included diabetes. Clinical record review revealed incidental physician orders were not added or changed to the monthly recap orders or medication records for five months. Resident #9's admission physician orders included the following:

A fingerstick blood sugar (FSBS) was to be done before each meal and at hour of sleep (9:00 PM). Novolin R (insulin, regular human) sliding scale was to be administered for the following FSBS

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results.
150 - 200 to receive 2 units regular insulin subcutaneous
201 - 250 to receive 4 units regular insulin subcutaneous
251 - 300 to receive 6 units regular insulin subcutaneous
301 - 350 to receive 8 units regular insulin subcutaneous
351 - 400 to receive 10 units regular insulin subcutaneous
If FSBS was less than 60, administer 1/2 ampule of D50 intravenously
If FSBS was greater than 400, notify physician.

Review of the physicians' orders revealed that on 11/30/09, the physician changed the 9:00 PM FSBS coverage to be 1/2 of the ordered sliding scale amount. This meant that if the 9:00 PM FSBS was 178, Resident #9 was to receive 1 unit of Novolin R instead of 2, and so on.

Review of the sliding scale coverage records in the MAR revealed the licensed nursing staff continued to administer the full dose of sliding scale insulin coverage at 9:00 PM for the past four months.

Resident #23

Resident #23 had been a resident at the facility since 7/17/09, with diagnoses that included diabetes, neuropathy and insomnia.

Review of the interim orders revealed the Neurontin had been increased to 400 mg three times a day on 2/25/10. On 2/26/10, an interim order was received for Risperdal 0.25 mg to be given twice a day and 0.5 mg to be given at

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F 309	Continued From page 55 bedtime, following a psychiatric evaluation Review of Resident #23's recap physician orders for 3/1/10-3/31/10, revealed an order dated 10/16/09, for Neurontin 300 milligrams every eight hours. The March recap did not contain the change of dose for Neurontin or the addition of Respirdal. Review of Resident #23's MAR revealed that the March MAR did not include the increased dose of Neurontin, nor the Respirdal order. The MAR did have documentation that indicated nursing staff administered Neurontin 300 mg every eight hours. There was no documentation that any Respirdal had been given. Review of Resident #23's medication packets revealed a blister pack identified as Neurontin 400 mg, one capsule, to be given to Resident #23 three times a day. This review also revealed a blister pack identified as Risperdal 0.25 mg, one tablet to be given in the morning and afternoon and a blister pack identified as Risperdal 0.50 mg, one tablet to be given at bedtime. These blister packs had evidence that medication had been dispensed. An interview on 3/11/10, with the Licensed Practical Nurse (LPN) who was the Unit Manager revealed that there was no evidence that licensed nursing staff followed correct procedure of medication administration, specifically: 1) Comparing the blister packs with the MAR to ensure correct patient, drug, route, dose, time regarding Resident #23. 2) Failed to follow the physician's orders regarding the sliding scale insulin administration for Resident #9.	F 309		

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F 309	Continued From page 56 Review of the facility policies for medication administration revealed medications were to be administered in accordance with written orders of the attending physician. The policies also directed that "prior to administration the medication and dosage schedule on the medication administration record was to be compared with the medication label." The policy further directed that this information "should be checked at least three times during the medication preparation. If there was a discrepancy, the physician's orders were to be checked."	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure 1 of 24 residents received a restorative program as ordered by the physician (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 11/12/09, with re-admission on 12/30/09. Diagnoses included diabetes, protein-calorie malnutrtion, abnormal weight loss, gastrostomy tube, and depressive disorder. Physician orders included a restorative program, with a start date	F 311		4/12/10

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F 311	Continued From page 57 of 1/18/10 for eight weeks, six times a week for bed mobility and to maintain range of motion and strengthening to decrease/prevent contractures. Review of the resident's record revealed that a restorative program for the resident had not been initiated, and a restorative care plan had not been developed. During the survey period, Resident #7 was observed to be bedfast. On 3/9/10 at 9:30 AM, the resident was asked about receiving mobility/strenghtening services, and she responded, "I would love to get up." On 3/9/10 at 9:45 AM, the Restorative Nursing Aide (RNA) was asked about the restorative program for Resident #7. The RNA stated, "I wasn't made aware of it. I think she (the resident) would benefit from it." At 9:55 AM, the nurse on B Hall reported, "She (Resident #7) hasn't had any RA. It would be good for her to get out of bed, for sure." On 3/9/10 at 10:00 AM, the Director of Education and Restorative Services was interviewed. The Director confirmed that she had not been made aware of Resident #7's restorative program order. The Director was unable to explain why she had not received the order. The unit nurse manager was interviewed on 3/9/10 at 10:10 AM, and the nurse stated, "We look at all the new orders daily. The DON (Director of Nursing) looks at the copies and distributes them. If she (the Director of Education) got the order, she would have given the order to the RNA."	F 311		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		4/12/10

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F 314 SS=D	Continued From page 58 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed for 1 of 24 sampled residents to provide care and services to promote the healing of a pressure ulcer (Resident #15). Findings include: Resident #15 Resident #15 was admitted on 2/22/10, with diagnoses including paraplegia, Stage IV pressure ulcer, and osteomyelitis. On 2/23/10, the facility developed a care plan with regards to Resident #15's pressure ulcer. One approach was documented as, "provide pressure relieving device for bed and wheelchair." On 3/10/10 at 2:10 PM, Resident #15 was observed up in a wheelchair in the therapy room. There was no pressure relieving cushion on the resident's wheelchair. On 3/11/10 at 11 AM, the Director of Nursing confirmed there was no pressure relieving	F 314		

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F 314	Continued From page 59 cushion for Resident #15's wheelchair.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to see that 1 of 24 residents received the appropriate services to restore as much bladder function as possible (Resident #4) and failed to assess and to justify the continued use of a Foley catheter for 1 of 24 residents (Resident #15) Findings include: Resident #4 Resident #4 was admitted to the facility on 11/13/09 with diagnoses that included post intracranial hemorrhage, debility, hypertension, depressive disorder and anxiety. She had a gastrostomy tube. On 2/24/10, an order was written to toilet Resident #4 every two hours, before and after meals, before bed and first thing in the morning	F 315		4/12/10

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for 14 days. When the bladder training form was reviewed, it was found that the resident was only toileted at 7:00 AM, 9:00 AM, 11:00 AM, and 1:00 PM on 2/25/10, and at the same times on 2/26/10. Documentation indicated that the resident was not toileted again until 3/5/10 at the times of 11:00 PM, and 4:00 AM. On 3/6/10, Resident #4 was toileted at 11:00 PM, 2:00 AM, and 5:00 AM.

An interview was conducted with the Staff Development Coordinator on 3/8/10. She related that she had personally shown staff the recording form , how to use it and explained the order for toileting the resident.

The facility policy entitled "Bladder Retraining" dated 3/2006 was produced. The policy stated "evaluate voiding pattern and toilet at the intervals." The policy also stated that the resident response and progress toward the goals should be documented on the Bladder Retraining form as long as the resident is in the program. The Staff Development Co-ordinator disclosed that the order was not followed as written and that due to the lack of data present, it could not be determined if the resident has the ability to be retrained.

Resident #15

Resident #15 was admitted on 2/22/10, with diagnoses including paraplegia, Stage IV pressure ulcer, and osteomyelitis. Documentation in the record indicated the resident had a Foley catheter on admission and continued to have the catheter in place.

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F 315	Continued From page 61 There was no documented evidence in the record the facility assessed the medical justification for the continued use of the urinary catheter. There was no documented evidence in the record the facility obtained a physician's order for the continued use of the urinary catheter. On 3/11/10 at 8:30 AM, the facility provided a policy titled, "Catheter/Urinary Catheter, Use of" with an original date of 7/2009. The policy stated, "A. Catheters are only used in those circumstances in which no alternative is available. Use is primarily restricted to:..3)Contamination of a Stage III or IV Pressure Ulcer where urine impedes healing..." There was no documentation in the record the facility assessed that the resident could not use a urinal to keep the ulcer from contamination. There was no documentation in the facility's policy of how the resident would be assessed for medical justification of continued use of the catheter. There was no documentation in the facility's policy of a need for a physician's order for the use of the catheter. On 3/11/10 at 8:45 AM, the Director of Staff Development (DSD) confirmed there was no physician's order for the continued use of the catheter. The DSD stated an order should have been on the record. When asked about the assessment for medical justification for continued use of the catheter the DSD replied, "Our protocol is a Foley For Stage III and IV."	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 322		4/12/10

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who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility document review, the facility failed for 1 of 24 sampled residents to ensure the proper volume of enteral feeding solution was provided to the resident in the time specified by the physician's order (Resident #12).

Findings include:

Resident #12

Resident #12 was admitted on 8/5/05, with diagnoses including diabetes, attention to gastrostomy tube, and dysphagia. Documentation in the resident's record indicated that Resident #12 required tube feedings. The physician ordered enteral feeding Glucerna 1.2 to be infused via feeding tube at 50 millimeters (ml) an hour for 20 hours.

On 3/9/10 at 9:20 AM, Resident #12 was lying in bed. The feeding pump was noted to be on and set to deliver 50 ml of enteral feeding per hour. A 1500 cubic centimeters (cc) bottle of Glucerna 1.2 was noted to be attached to the pump. There were 1200 cc left in the bottle. According to the label on the bottle, the bottle was hung on 3/8/10 at 9 PM. According to the physician's order, Resident #12 should have received 600 cc of

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F 322	Continued From page 63 feeding from 3/8/10 at 9 PM to 3/9/10 at 9 AM. The bottle indicated the resident received 300 cc or half the amount. On 3/9/10 at 11:55 AM, a Licensed Practical Nurse (LPN) identified as responsible for Resident #12's care stated that 20 hour tube feedings "run from 4 PM until the dose is completed, usually finishing around 12 noon." The LPN stated that the machine was set to deliver the 1000 cc the resident was to receive in 20 hours and would alarm to notify the staff the feeding was complete. When told of the findings, the LPN stated, "The machine is set to deliver the 1000 cc. It may take longer than the 20 hours." The LPN was unable to state why the feeding was 300 cc behind schedule. On 3/10/10 at 7:40 AM, the Director of Staff Development (DSD) was in Resident #12's room. The DSD stated 20 hour feedings were to run from 4 PM to 12 PM the next day. The DSD stated the nursing staff were instructed to clear the pump at 4 PM. The DSD further stated the oncoming nurse for each shift was to check the amount infused when the nurse started the shift so that if the feeding was not on schedule the reason why could be explained by the nurse going off shift. When the DSD checked the pump for the amount infused the pump monitor read, "5112 cc." The DSD stated, "It doesn't look like the nursing staff has cleared the pump." The facility's policy titled "Enteral and Parenteral Feedings" with an original date of 3/2006, did not address the procedure the nursing staff was to follow when using a pump to deliver enteral feedings.	F 322		
F 325	483.25(i) MAINTAIN NUTRITION STATUS	F 325		4/12/10

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F 325 SS=D	Continued From page 64 UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility document review, the facility failed for 1 of 24 sampled residents, to provide care and services consistent with the resident's comprehensive assessment and care plan to maintain weight (Resident #14). Findings include: Resident #14 Resident #14 was admitted on 2/23/09, with diagnoses including dysphagia, carotid artery occlusion, and muscle weakness. On 3/9/10 at 12:30 PM, Resident #14 was observed to eat 60% of the lunch meal. The resident stated, "I can't eat anymore." The facility developed a care plan in regards to Resident #14's risk for weight loss. One of the approaches was to monitor intake amounts. A	F 325		

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F 325	Continued From page 65 review of the Activity of Daily Living sheets for January 2010 meal intake revealed for 1/21, 1/25, and, 1/28/10, the breakfast and lunch intakes were not documented. The dinner intakes were not documented for 1/5, 1/7, 1/14, 1/28, 1/30, and 1/31/10. For the month of February 2010, the breakfast and lunch intakes were not documented for 2/11, 2/14, and 2/18/10. Documentation on the weight record for Resident #14 indicated from 12/3/09 through 3/7/10, Resident #14 lost 8.6 pounds. There was no documented evidence a referral was made to the Registered Dietitian to assess factors related to the resident's weight loss. On 3/10/10 at 8:20 AM, observation and calculations revealed the resident had consumed 40% of the breakfast meal which consisted of a donut, 1/2 cup hot cereal, scrambled eggs, 240 cc of milk, a piece of toast with a pat of margarine. A certified nursing assistant (CNA) was then asked to calculate Resident #14's breakfast intake. The CNA studied the tray and stated the resident had eaten 80% of the meal. When asked how the CNA came to the conclusion, the CNA stated that the resident had eaten the donut, drank half of the milk, ate half of the cereal, and drank two cups of coffee. On 3/10/10 at 8:30 AM, the Director of Staff Development (DSD) was shown the same tray. The DSD stated, "The resident ate 40-50%. When asked, the DSD stated coffee was not counted in the percent of meal consumed, but was counted in the fluid intake total. When shown the pattern of weight loss in Resident #14, the DSD said that she, "will tell the dietitian."	F 325		
F 332	483.25(m)(1) FREE OF MEDICATION ERROR	F 332		4/12/10

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F 332 SS=E	Continued From page 66 RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a medication error rate that was less than 5% in 2 of 2 medication observations. Medication pass observations were conducted on two separate halls, on 3/9/10, for a total of 40 medication opportunities. Ten medication errors were observed resulting in a 25% medication error rate. Findings include: By definition, a medication error is an observed preparation or administration of drugs or biologicals which are not in accordance with the physician's orders, manufacturer's specification for the drug and accepted professions standards and principles. The following medication errors were observed. A licensed practical nurse (LPN) was observed passing medications from 8:30 AM to approximately 9:00 AM on 3/9/10. The following errors were observed during this medication pass. Resident #28 On 3/9/10, Resident #28 received seven	F 332		

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medications. These medications were:
Aspirin chewable 81 milligrams (mg)
Omeprazole delayed release capsule 20 mg
Levitiracetam 500 mg
Oxybutain 5 mg
Topamax 50 mg
Two medications were in liquid form.
Docusate 100 mg/10 cubic centimeters (cc)
Guaifenesin 100 mg/5 cc

These medications were administered through a gastrostomy tube. Five medications were pills. The LPN altered their shape either by crushing or separating the capsules to be able to pass through the gastrostomy tube. An interview with the LPN during this medication administration revealed that although Resident #28 was able to consume food, a mechanical soft diet, but that the medications were given through the gastrostomy tube. The LPN did not prepare the medications with applesauce so they could be administered orally.

Review of the physician orders revealed that all of Resident #28's medications were ordered to be given orally. There was no physician's orders to indicate that these medications could be given by gastrostomy tube. The physician orders also specified the Ducosate was to be a pill.

Review of the Medication Administration Record (MAR) revealed no documentation that Resident #28's medications were to be crushed and administered through the gastrostomy tube.

Review of Resident #28's clinical record revealed no evidence of communication by the facility to inform the physician of Resident #28's need to have medication crushed and administered

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through the gastrostomy tube. There was no evidence to reflect the facility had requested the Ducosate to be changed to a liquid form.

Review of the facility policies regarding medication administration specified:
page 3,(20 F) The need for crushing medications is indicated on the patient's MAR, so that personnel administering medications are aware of this need and the Consultant Pharmacist can advise on safety and alternatives if appropriate during MAR reviews.

Resident #29

Resident #29 was to receive nine medications. Of these nine medications, it was observed that the LPN performing the medication pass, administered Aspirin 81 mg enteric coated and Prilosec 20 mg extended release as part of the nine medications Resident #29 received.

Review of the MAR and the physician orders revealed the Aspirin was not ordered as enteric coated. The Prilosec was not ordered as extended release.

The nurse stated she gave the enteric coated aspirin to Resident #29 because " if a resident can swallow pills whole, enteric coated is given, otherwise a chewable aspirin is given."

There was no evidence the physician was aware of this practice, or that the facility had a policy to this effect.

The facility could not provide any policies that enteric coated Aspirin or extended release Prilosec could be substituted if not specified.

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F 332	Continued From page 69 During observation of a medication pass on Station 1 during the morning of 3/9/10, it was noted that Synthroid was given orally to Resident #2. The directions for administration of the medication was that it was to be given before breakfast. The resident had already eaten his morning meal.	F 332		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed for 1 of 24 sampled residents, to ensure the resident received nectar thick liquids as ordered by the physician (Resident #13). Findings include: Resident #13 Resident #13 was admitted on 3/27/09, with diagnoses including senile dementia, adult failure to thrive, and chronic airway obstruction. On the Minimum Data Set admission assessment with a reference date of 4/7/09, the facility documented the resident had chewing and swallowing problems. The physician ordered a mechanical soft diet with nectar thick liquids on 4/9/09. On 3/9/10 at 12:15 PM, Resident #13 was	F 365		4/12/10

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F 365	Continued From page 70 observed in the dining room. A Licensed Practical Nurse (LPN) fed Resident #13 the lunch meal. Included on the lunch tray was a cup of coffee. The coffee was not thickened. The LPN feeding the resident confirmed the coffee was not thickened. The LPN stated that the Certified Nursing Assistants were to thicken the coffee when they served the resident's tray. The tray card on the resident's lunch tray indicated the resident was to have nectar thick liquids. The facility's policy titled "Thickened Liquids: Management of Hydration for Patients/Residents" with a revision date of 7/2009 read, "8. Verify that all thickened liquids are being served according to the stated physician's order."	F 365		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner. Findings include: A tour of the facility's main kitchen and	F 371		4/12/10

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F 371	Continued From page 71 nourishment rooms on 3/8/10 at 8:40 AM revealed the following: 1. There was a layer of ice across the floor of the walk-in freezer. The dietary director explained that the ice was due to the door staying open during deliveries. 2. There was a leak in the drain line of the 3-compartment sink. 3. The pH of the quaternary-based sanitizing solution in a wiping cloth bucket was over-concentrated at above 500 parts per million (ppm) (proper concentration is 150-200 ppm). According to the facility's policy on sanitizing, dated 8/2008, "A high concentration of sanitation solution may be potentially hazardous." 4. Staff food was being stored in the reach-in refrigerator with resident food. According to the facility's "Safe Food Handling" policy, dated 8/2008, "All foods and beverages in the facility that belong to employees are stored in employee refrigerators or other designated areas." 5. Sanitized pans were "wet-stacked" on racks. All of the above findings were confirmed by the dietary director.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		4/12/10

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F 428	Continued From page 72 This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review and interview, the facility failed to ensure the pharmacist reported drug irregularities during monthly drug regimen review of 1 of 24 sampled residents (Resident #9) and 1 of 5 unsampled residents (Resident # 28). Findings include: Resident #9 Resident #9 was admitted to the facility on 8/20/09, with diagnoses that included diabetes. Clinical record review revealed that on admission, Resident #9's physician orders included the following: A fingerstick blood sugar (FSBS) was to be done before each meal and at hour of sleep (9:00 PM). Novulin R (insulin, regular human) sliding scale was to be administered for the following FSBS results. 150 -200 to receive 2 units regular insulin subcutaneous 201 -250 to receive 4 units regular insulin subcutaneous 251 -300 to receive 6 units regular insulin subcutaneous 301 -350 to receive 8 units regular insulin subcutaneous 351 -400 to receive 10 units regular insulin subcutaneous If FSBS was less than 60, administer 1/2 amp of D50 intravenously If FSBS was greater than 400, notify physician. Review of the physicians' orders revealed that on	F 428		

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F 428	Continued From page 73 11/30/09, the physician changed the 9:00 PM FSBS coverage to be 1/2 of the ordered sliding scale amount. This meant that if the 9:00 PM FSBS was 178, Resident #9 was to receive 1 unit of Novulin R instead of 2, and so on. Review of the medication administration records (MAR) for the months of December 2009, and January, February and March, 2010 revealed the original order had not been discontinued and the sliding scale rewritten to include the new change. It was also observed that although the change was included in the MAR, it was not on the same page as the original sliding scale order. Review of the sliding scale coverage records in the MAR revealed the licensed nursing staff continued to administer the full dose of sliding scale insulin coverage at 9:00 PM for the past four months. Review of the pharmacy monthly review notes revealed no indication the pharmacist was aware of the non-compliance with the physician's orders regarding Resident #9's sliding scale insulin coverage. An interview with the Pharmacist by telephone 3/9/10, revealed the pharmacist acknowledged he did mention this discrepancy to the staff, but acknowledged he did not document this. The pharmacist also stated that he recalled the staff told him that if the FSBS was greater, that Resident #9 was to get the full dose. The Pharmacist acknowledged he did not know what "greater" meant, and that there were no orders specifying this. Review of the facility's policy for drug regimen review developed 4/2003, described that findings and recommendations were to be reported to the Director of Nursing.	F 428		

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F 428	Continued From page 74 Resident # 28 Review of the facility policy for "prescriber medication orders" described what should be included in the orders."#8 Route of administration, if other than oral." A medication pass observation at 8:30 AM on 3/9/10, revealed the licensed practical nurse(LPN), administering crushed medications to a resident with a gastrostomy tube. This resident was Resident #28. Review of the physician orders revealed these medications were to be given by mouth. There was no alternative option of administration by gastrostomy tube. Review of the MAR also indicated these medications were to be given orally. An interview with the Pharmacist by telephone 3/9/10, revealed the Pharmacist acknowledged that he thought the medications could be given either orally or through the gastrostomy tube to Resident #28. He acknowledged he was not aware the physician orders specified the medications to be given orally.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		4/12/10

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F 441	Continued From page 75 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure infection control practices and policies were followed for prevention of cross contamination while filling water pitchers, proper hand washing techniques, opened supplement cartons, screening staff and volunteers for communicable diseases and bio-hazard practices in clean med rooms.	F 441		

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F 441	Continued From page 76 Findings include: During the initial tour of D hall at 9:00 AM on 3/8/10, it was observed that a staff member was filling resident water pitchers from an ice chest. It was observed that the water pitchers had lids that could act as drinking cups. The staff member removed the lid, dumped the water into a basin and then filled the pitcher with ice from the ice chest using a scoop. It was observed the staff member would make contact with the mouth of the pitcher and the scoop, often tapping the ice scoop against the pitcher to knock the ice into the pitcher. The scoop would then be placed in the ice chest while the staff member returned the pitcher to the resident's room. A second observation was made with a second staff member, a certified nursing assistant (CNA). This CNA was observed filling water pitchers in D hall. The CNA came out of a resident's room carrying a covered water glass with a straw and the covered water pitcher. The CNA opened the lid of the the ice chest. It was observed at this time that the ice scoop and handle was lying directly on the surface of the ice. The CNA removed the lid from the glass, filled the glass with ice and replaced the scoop directly back onto the ice. The CNA put the lid back on the glass. The CNA then removed the lid off the pitcher, filled the pitcher with ice and then replaced the scoop directly back onto the ice. The CNA was interviewed at this and acknowledged the ice scoop should have been kept in the covered scoop holder located in the front of the ice chest. The CNA could not explain why she returned the scoop into the ice chest. The CNA acknowledged that the handle of the	F 441		

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scoop was contaminated because she held both the glass and the pitcher as well as the scoop, transferring any resident contact onto the scoop handle.

During medication pass on 3/9/10, administration of medication through a gastrostomy tube was observed. The licensed practical nurse used gloves while administering the medications through the gastrostomy tube, changing her gloves three times during the administration. The nurse washed her hands after the end of the medication administration.

A review of the facility policy revealed staff should wash their hands after every glove change.

On 3/8/10 at 3:45 PM, an opened carton of a high-calorie, high-protein supplement was observed on a medication cart on D Hall. The temperature of the supplement was 69.0 degrees Fahrenheit (F). According to the information on the carton, the supplement was milk-based, and the unused portion was to be resealed and refrigerated. The medication pass nurse communicated that the carton had been opened at 7:00 AM, and had not been refrigerated all day. Review of the facility's policy on supplements, dated 7/2009, revealed the following procedure: "If partial containers are left after a medication pass, store remaining product in the nourishment room refrigerator for no more than 48 hours and use at the next medication pass."

It was observed on two occasions (3/9-3/10/10) in both dining rooms that residents, who were served milk and milk supplements, were not given glasses in which to pour the milk or given straws to place into the milk cartons. The cartons were

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opened and the residents drank directly from the carton. When staff were asked about the absence of glasses and straws, they replied that they could get glasses and straws if needed but they had never used them. All other beverages, juices and water, came from the kitchen in glasses. Drinking directly from the milk products cartons increased the opportunities of contracting an illness, since sanitary storage and cleanliness of the cartons could not be guaranteed.

During an observation of the Medication Room on station 1, on 3/10/10, it was noted that there was a laboratory centrifuge present. Employee #28 confirmed that the centrifuge was used to "spin" down blood specimens. Laboratory specimens, which are potentially biohazards, should not be stored and/or spun down in a clean area such as a medication room.

Review of the personnel file for Employee #2 failed to disclose any evidence that the employee had any type of tuberculin skin tests. An employee from Human Resources, confirmed that the employee did not have any tuberculin skin tests and that she should have had the test completed.